

each group had outstanding debts of \$500 or more.

The Economic Research Department of the A.M.A. secured additional data on the 1960 assets and 1959 income of the respondents in the 1960 Survey of Consumer Finances. The data are as follows:

The median value of total assets held by over-65 spending units was \$8,124 in 1960, almost twice as much as the \$4,663 which was the median value of total assets of all other age groups.

The median value of home equity for over-65 spending units was \$4,559. This is almost 4½ times as much as the \$1,028 reported for younger spending units.

The median value of liquid assets was nearly 2½ times as much for over-65 spending units—\$1,012 compared with \$460.

Some 64 per cent of the over-65 spending units owned homes; 53 per cent of the younger units. Among the over-65 spending units, 53 per cent owned mortgage-free homes compared with 18 per cent of the younger group.

On the basis of 1959 figures, 74 per cent of the older spending units had no personal debt, compared with 34 per cent of the younger units.

Of all aged spending units, only 3 per cent owed more than \$1,000, compared with 20 per cent of the younger groups. Some 8 per cent of the older group had debts between \$200 and \$1,000, compared with 28 per cent of younger units; and 15 per cent had debts under \$200 compared with 18 per cent of younger spending units.

Some 86 per cent of the over-65 spending units in the 1960 survey had no installment debts. By comparison only 48 per cent of the younger units said they owed no installment debts.

In commenting on the comparison of income between the older age group and the total sample, the *A.M.A. News* article of October 15, 1962, notes that, "a comparison of income . . . should include adjustments for Old Age Assistance recipients and for relief given those over 65 through double income tax exemptions, full medical expense deductions, and exemptions of social security and other retirement benefits and income."

The Bureau of Research and Planning wishes to note that, for purpose of clarification, the data and text attributed to the Economic Research Department vary somewhat from those published in the October 15 issue of the *A.M.A. News*.

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Rural Health*

IN SIX WESTERN STATES† the words *rural health* do not mean what they did forty years ago when the American Medical Association first took official notice of the status of medicine in rural America.§ Current meaning was made very clear at Sacramento last month when delegates from the six states met in the Fourth Regional Rural Health Conference sponsored by the A.M.A. Council on Rural Health.

Rural health today is not one subject but three. There is health of that segment of the population, largely native, living in rural areas. There is an entirely different situation regarding health of a group greatly expanded in recent years, the migratory laborers in agriculture and, finally, it appears that there is emerging another group whose members no longer migrate. They have been called, "workers seasonally employed in agriculture."

It is clear that needs of these three groups differ markedly. At the Sacramento conference it appeared that many of the original problems relative to health in rural areas have been solved. Medical training, transportation, communication, transmission of electronic data, and dwindling rural population have combined to make rural and urban care essentially equal.

Progress in providing health services for migrant workers has been slow. They have the highest rates for infant mortality, lowest rates for immunizations, and low rates for utilization of medical care. California with approximately 250,000 migrants (workers and dependents) has the greatest problem. There the growers and physicians in private practice have been cooperating to bring modern care to these people. Under a law passed by the 1961 legislature, ten county plans are being developed and it is expected that others will follow. Most of these are prepayment plans. California Physicians' Service has sponsored a pilot plan in Tulare County in order to obtain actuarial experience not now available. Others are in various stages of development but it is expected that several will be in operation with the 1963 growing season.

In Idaho it is recognized that the migrants need better housing, better school opportunities and more health programs for those who become ill. County hospitals now provide care and public health nurses call on the chronically ill. Physicians in eastern Washington have assumed traditional responsibility for giving care to the needy but have also developed

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†Arizona, California, Idaho, Oregon, Nevada, Washington.

§The House of Delegates took action, May, 1922, on shortage of physicians in rural areas. A Committee on Rural Medical Service was formed in 1945 and changed to the Council on Rural Health in 1951. The Council is a standing committee of the Board of Trustees and is directed by the Division of Environmental Medicine.

a prepayment plan, covering the worker only, paid for by the employer.

One of the most interesting developments in rural health is reported from Kern County, California. This work is with the third group, the non-migratory workers and their families. Mexicans predominate and their greatest need was for health education but language and cultural differences interfered. Finally it was decided to recruit health educators from the worker group. They were brought in to the health department where they were given a broad, practical education in hygiene, sanitation, nursing, child health, nutrition, and availability of commu-

nity health resources. Thus prepared, the health educators went back to their own people where they were understood and where they were able to exert influence previously impossible for those who did not speak Spanish and who did not recognize the importance of Mexican cultural background.

Theme of the Sacramento conference was "Good Rural Health—Everybody's Business." It soon became apparent, however, that rural health is a triad rather than unity, and that it is achieved, not by everybody, but by individuals, working as rural people have since time immemorial—for themselves—and some of the time for each other.

LETTERS *to the Editor*

Decrease in Serum Cholesterol With Surgical Stress

THE INTERESTING OBSERVATIONS of Goodman and associates in the November issue of CALIFORNIA MEDICINE prompts us to comment on analogous serum lipid and lipoprotein measurements currently being performed in our laboratories. Thus far, blood has been collected from over 50 patients immediately before surgery, at 30-minute intervals after induction of anesthesia and within 1 to 2 hours post-operatively. Approximately one-half of the subjects exhibited moderate to marked reduction in lipemia. Decreases in serum total and beta lipoprotein cholesterol concentrations were accompanied by diminutions in amounts of lipoproteins of S_t 0-400. Lipopenic responses were frequently most striking 30 minutes postinduction whereas smaller depressions obtained thereafter. These findings are consistent with those of Goodman and co-workers.

The rapid rate at which serum lipid parameters are lowered during surgery may suggest a relation-

ship to other factors as well as stress. For example, a number of commonly used inhalation anesthetics are efficient lipid solvents. In our laboratories, treatment of serum with many of these agents produced declines in lipid and lipoprotein levels not unlike those often noted in anesthetized patients. It is noteworthy that the degree of lipopenic response *in vitro* was a characteristic property of each inhalation anesthetic studied. Moreover, our data indicate that the lipid-lowering capacity of some surgical anesthetics may be correlated with pharmacologic activity. A brief summary of our preliminary studies appeared in the October 1962 issue (Part 2) of *Circulation*. A more detailed report will be published shortly.

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